

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005075	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/28/2014
NAME OF PROVIDER OR SUPPLIER ST VINCENT HOSPITAL & HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of one (1) State complaint.</p> <p>Complaint number: IN00138509 Unsubstantiated; lack of sufficient evidence</p> <p>Date of survey: 8/28/14</p> <p>Facility number: 005075</p> <p>Surveyor: Marcia Anness RN Public Health Nurse Surveyor</p> <p>St Vincent Hospital & Health Services is in compliance with 410 IAC 15-1.5-5, Medical staff, Hospital Licensure Rules.</p> <p>QA: cloughlin 10/31/14</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE